CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056327	A. BUILDING _____ B. WING _____	04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ROSSMOOR	1224 ROSSMOOR PARKWAY, WALNUT CREEK, CA 94595 CONTRA COSTA COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted], HFEN CLASS AA CITATION -- PATIENT CARE 02-1599-0004967-F Complaint(s): CA00133368, CA00133368 483.25(K)(4) The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on staff interview and record review, the facility failed to ensure that staff provided proper ventilation to Resident A by failing to cover the stoma and to ventilate the resident through the mouth using an Ambu bag when the attempts to replace the tracheostomy tube were unsuccessful and the resident exhibited signs of distress. This failure resulted in the resident's demise. Findings: Resident A was a 56 year old male, re-admitted to			

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	Continued From page 1 the facility on 4/6/07 with multiple medical conditions, including respiratory failure. Resident A had a tracheostomy (surgical opening through the neck into the trachea [windpipe] to allow for ventilator induced breathing in patients with respiratory failure) and was ventilator (equipment that mechanically supplies oxygen) dependent for his respiratory function. The resident was comatose and was totally dependent on staff for all the activities of daily living. He had a physician order for monthly change of the Portex #7 tracheostomy (trach) tube by the respiratory therapist (RT). On 11/24/07 at 5:20 p.m., Nurse 3 documented that at approximately 4:25 p.m. she was called by the RT 1 to assist with the trach tube change. Nurse 3 noted that the resident's oxygen saturation (O2 sat-a measurement of oxygen concentration in the blood) at the beginning of the procedure was 99% (normal values 95%-100%), his heart rate/pulse was 89 (normal rate 60-100 beats/min), and he was in no respiratory distress. According to Nurse 3's note, the respiratory therapist inserted a size #7 trach tube into the stoma (opening to the trachea) but was unable to suction Resident A. The resident's O2 saturation and pulse rate began to decline. Nurse 3 documented, "Just after insertion of 1st trach #7 by RT, RT suctioned but unable to go through, O2 SAT went down to 80%, P (pulse)-60. Frank blood spurts out from the trach site." According to the "Continuous Ventilator Flowsheet," dated 11/24/07 at 4:20 p.m., RT 1			

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	Continued From page 2 removed the trach tube with some resistance and attempted to insert a new tube, “going in approx. 1’’ before severe resistance was met. Pt (patient) became increasing restless.” RT 1 attempted suctioning but met resistance, and the resident could not be ventilated by Ambu bag (hand-held device used to provide ventilation to a patient who is not breathing or is breathing inadequately) through the stoma. The charge nurse was called. RT 1 inserted another #7 tube and the "same problems occurred." According to RT 1’s documentation, the ventilator’s alarm went off when RT 1 attempted to suction Resident A. The record showed that at the time, the resident's heart rate decreased to the 50's and 40's and the oxygen saturation went down to the 70's. RT 1 documented, "Pt's condition appeared compromised as pt's neck began to swell." 911 was called. A third attempt was made with a #6 Portex tube and the "same problems continued." According to RT 1's note, Resident A had no breathing sounds and his face and neck increased in size. The paramedics arrived and attempted intubation, but the resident could not be ventilated. RT 1 wrote "Approx(imately) at 1645 (4:45 p.m.) pt's condition had deteriorated to no pulse, still chest and flat line on paramedics monitor." Resident A was pronounced dead at 4:50 p.m. The facility policy for "Tracheostomy Tube Change, reviewed on 11/29/07 instructed, "In the event you are unable to insert a tube of the same size as the one removed, immediately follow the last step with a tube one size smaller." By not inserting a trach tube of a smaller size as soon as the attempt to			

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	Continued From page 3 insert a tube of the same size was unsuccessful, RT 1 did not follow the facility policy for trach tube change. During an interview on 11/29/07 at 1:35 p.m., RT 1 stated that looking back at the incident, "probably I would have gone for a #6 as soon as the #7 did not go in", and "I would bag him, cover the stoma and ventilate with mask instead of trying to achieve airway through the stoma." Resident A's physician, Physician 2, was interviewed on 12/4/07 at 4:58 p.m. and stated that Resident A did not have any upper airway obstruction that would have impeded the ventilation through his mouth. The physician further stated that the resident's ventilation should have been maintained by covering his stoma, covering his mouth with a mask, and Ambu-bagging him until the paramedics arrived and the patient would then have been intubated and transferred to a hospital. Nurse 3 stated on 12/6/07 at 9:40 a.m., during a phone interview, that at the first attempt to insert a new tube, "blood sprayed from the stoma" and "blood came all over my upper arms and on my face, on my forehead." Nurse 3 stated that she was aware of the resident's oxygen saturation and heart rate was declining. She further stated that at no time did she or the RT cover the resident's stoma then mask and ventilate him through the mouth. Lead RT, interviewed on 12/7/07 at 11 a.m., stated that during a trach tube change, a small amount of			

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blood was common, but a larger amount would mean injury to the stoma. She further stated that when a patient's oxygen saturation goes down into the 80 %, 911 should be called, the stoma should be covered and the patient should be ventilated through the mask. Lead RT also stated during the interview that swelling of the patient's face and neck, and resistance felt on suctioning, were indicators that the tube was not in the trachea, and that the air was escaping under the subcutaneous tissue (under the skin).

The facility's Subacute Unit Manager stated on 12/7/07 at approximately 11:15 a.m. that it was the facility usual procedure to maintain an adequate airway at all times. "Cover, mask, and bag", the manager stated. He further stated that Resident A was routinely bagged during weekly showers.

During a phone interview on 3/27/08 at 1:35 p.m., Physician 4 stated that the autopsy identified no obstruction that would have impeded the ventilation through Resident A's mouth. The Coroner's report, dated 4/16/08, confirmed and supported Physician 4's statement.

The facility's failure to provide adequate ventilation to Resident A, by not covering the stoma and ventilating him through the mouth using a mask and Ambu bag presented an imminent danger to the resident and was a direct proximate cause of the death of Resident A.

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